Services for Supporting
Family Carers of Elderly People in Europe:
Characteristics, Coverage and Usage

EUROFAMCARE

National Background Report for Finland

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Content

Summary of Main Findings

- The structure of the Finnish society has been based on the welfare state model, where the government plays an important role in both income transfer and in organizing education, health, social, cultural, and other services. Services are mostly provided by the municipalities and income transfer is organized by state finances and statutory insurances.
- The service development implemented in the early 1990s, the state subsidy reform, and the recession in the 1990s have all contributed to the development of care and services for older people. The number of persons working in the municipalities decreased in the early 1990s starting to increase again in the mid-1990s. The service provision in private enterprises and organisations grew in the end of 1990s, but the number of persons working in municipal care and services for older people decreased disproportionately to the population of persons aged over 75 years in the 1990s. For example, regular home-help services, long-term institutional care and services in health centres have obviously decreased. At the same time the proportion of persons in service housing and in the service housing of 24-hour assistance has increased.
- After the state subsidy reform in 1993, state contribution decreased significantly, but increased again in 2001. At the moment the municipalities have more responsibility in deciding what kind of services they offer and the criteria for the financial support, which normally is based on the dependent person's need estimated on the basis of his / her functional capacity. The municipalities have varieties of services and levels of financial support for informal care. Presently the open care services are emphasized in social and health care and their development is in progress. The aim is to enable older people to live in their own homes for as long as possible, and often they prefer staying at home to institutional care. However, part of older people will always need institutional care, especially those who are suffering from dementia or have nobody to care for them.
- Families are expected to take more responsibility for their older members in need of care, but they are also provided with services arranged by municipalities. Personal care and service plans are made by a multiprofessional team for persons in continuous need of care. The family caregiving is mainly supported by two different means. It is granted as funding for informal care and / or different kind of services provided by the municipality.
- In Finland the selection of services for older people has been limited to light open care such as home help and home nursing a couple of times per week or heavy institutional care. In the future, the purpose is to develop services more flexible and multifaceted to cover the variety of needs of older people at different stages of disability.

- Presently the services provided by the municipality mostly include home help, home nursing, living dependent on services, day centres, meals on wheels, transportation for disabled people, and financial support for informal care.
- Family caregivers' well-being has also been focused on by offering them day-offs and possibilities for rehabilitation and relaxation. There are also dozens of projects for supporting family caregiving in Finland. Mostly the projects are organized by various associations and funded by The Finnish Slot Machine Association. In addition, the municipalities fund their own projects.
- There are four major associations for older people in Finland. The Association of Care Giving Relatives and Friends aims at improving the situation of the carers and dependent. The association has been functioning for twelve years and it is nationwide and bilingual (Finnish and Swedish). Among the most important fields of action, this association provides legal advice, guidance and counselling, delivers information, as well as organizes group meetings, holidays and rehabilitation courses for caregivers. This association is the only one which focuses on caregivers while the focus of other associations is on older people in general. However, it is very often difficult to get the older spouses working as caregivers involved in the association's activities, because they may not identify themselves as caregivers even though they may care for very disabled persons.
- The Central Union for the Welfare of the Aged focuses on improving the welfare and social security of the aged. The Union offers counselling and guidance in order to develop the activities of the member organizations. It also provides information on current issues concerning the welfare of the aged for the member organizations on the local level. It has been very active in the area of pilot projects developing services for the aged.
- The Association for Old Age and Neighbour Service promotes the interests of its member associations and provides resources for development. The majority of the services of the member associations are offered directly to homes and aim to facilitate living at home.
- The Association of Alzheimer´s disease advocates the rights of demented people and their relatives. It is an international association.
- In Finland there are several laws, which define the social and health services and the rights and treatments of clients. The importance of family caregiving has been noted in the Finnish society also by policy makers. Very old and very frail people are cared for at their own homes. Without family carers there would be a lot more pressure for institutional care. The administrator set by the Ministry of Social Affairs and Health, has quite recently given a proposal for developing the carers' status as a part of

social and health services. The report was released in the end of March 2004. In this report sixteen improvements have been proposed concerning e.g. the carers' well-being, pay and leisure (See chapter 6.1). The aim is to give the family caregiver the status of a municipal worker. These changes will be introduced gradually and completed by 2012.

Introduction – An Overview on Family Care Demographic trends related to family care-giving (supply and demand)

The future development of population age structure has recently been of great concern to policy makers. Currently the average retirement age in Finland is 59, which is the lowest in the OECD –countries. By 2030 the number of retired people will increase and the predictions indicate shortage of labour force. At the same time the number of one-person households and persons aged 75 years and need a lot of care and services will increase which in turn will contribute to a greater demand of services.

Table 1 shows the predicted age distribution of the Finnish population for 2010-2030. The share of persons aged 65 years or older is growing while the share of people in working age is decreasing.

Table 1: The predicted age distribution of Finnish population for 2010-2030

	Unit	2010	2020	2030
Population	1,000	5,268	5,317	5,291
0–14 yrs	%	16	16	15
15–64 yrs	%	67	61	59
65– yrs	%	17	23	26

Source: http://www.tilastokeskus.fi/.

In estimating the quantity and assessing the quality of services provided for elderly people, the criterion age has been 75. According to official estimates, the number of people aged 75 years and older in Finland will be 400 000 in 2010, almost 500 000 in 2020, and about 700 000 in 2030. Presently 8 % of people aged over 75 years are in institutional care and 5 % living dependent on services. Twelve percent of that age group manage at their own homes with regular home help or home nursing. Except for the home services, the target of old age strategy has almost been reached. The aim is that by 2007 home services will cover 25 % of the population aged over 75 years (Aaltonen 2004). The increasing number and share of people aged 80 years or older is an essential matter from the point of view of service system. In 2002 the share from the total population was 3.6 % and it has been estimated to grow to 5 % by 2020 (http://www.tilastokeskus.fi/).

Research has shown that in the future older people would like to give more responsibility to relatives for their care (Vaarama et al.1999a). Significant part of daily activities (cleaning, shopping, laundry etc.) of older people are taken care of by relatives either with financial support for informal care or without any social support. According to the report on support for informal care, people in-

volved in family caregiving (including carers of dependents in all age groups) are mostly family members: spouses (43 %), children (22 %) or parents (22 %). The proportion of men as informal carers has increased (Vaarama et al. 2003b).

Social and health services are provided first of all by municipalities within the framework set by government. Municipality's responsibility for organizing the services is based on law. However, due to the unbalance between need and supply, the municipalities may not be able to provide all the services by themselves. In that case they buy services from private sector, the share of which as service provider has increased during the past few years.

The care market is reasonably well organized with no major problems. In the welfare state model municipalities are responsible for arranging the social and health care services. Since the early 1990s, when the service development was implemented, the number of services provided in the private sector has increased. In 2000 the private service providers accounted for 21 % of the personnel in the field of social and health care (Kauppinen et al. 2003). The services of the private sector are regulated by different laws and permissions, and the activities are supervised by e.g. National Authority for Medicoleagal Affairs and State provincial office. The qualifications are the same for both municipal and private sector workers.

People are continuously interested in voluntary work. E.g. many functionally capable pensioners are volunteers in different organizations. The balance between demand and supply depends on municipality, but it seems that the need for volunteers is always greater than the supply. Finland's Red Cross organizes introductory training for those who are interested in voluntary work in the organization's activities. The church also organizes activities in various groups for older people, such as discussion groups, trips, activities organized by local parishes. The priest and other personnel working in the parish also make house calls. The most important part of informal care is, however, given by the spouse and children. Altogether the help from neighbours, other relatives and friends accounts only for about one percent. The help of neighbours is mostly temporary and depends a lot on people. Some people have good social networks; especially in rural areas people are more used to help each other.

The trend in the health status of the population should always be taken into account when future need for services is estimated. According to available age cohort studies, there has been positive change in older people's health and functional status, which may contribute to the need of services.

In Finland over 90 % of older people live at home by themselves or supported by a relative or a significant other. According to Vaarama and Kaitsaari (2002) the number of persons aged 60 years or over, who were living in their own homes and in need of informal care, was 133,000 (about 10 % of people over 60 years of age). However, there were 15,901 (about 2 %) persons aged over 65 years who were receiving governmental support for informal care, which is

given to a person who is a family caregiver. The majority of informal care clients were over 65 years of age and the most common factors causing need for care were an age-related decrease in functional capacity and long-term physical illness or injury (Vaarama et al. 2003a).

In estimating the quantity and assessing the quality of services provided for elderly people, the criterion age has been 75 years. About 70-75 % of people aged over 75 years get along without societal services. The older people are very often able to cope with their every-day life at their homes with help from relatives and friends (Luoma et al. 2003, 24-25). The utilization of services among older people seem to be strongly associated with age, physical, mental and social functional capacity, living alone, housing, living environment, the functioning of social networks and the help offered by relatives and significant others (Vaarama and Kaitsaari 2002). In the future the increasing number and share of people aged 80 years or older is an essential matter from the point of view of service system. In 2002 the share from the total population was 3.6 % and it is estimated to grow to 5 % by 2020. This is expected to contribute to the increase in the need of services.

Following the state subsidy reform in 1993 state contribution to service financing decreased significantly, but increased again in 2001. Due to this reform institutional care was reduced and replaced by service housing and service housing with 24-hour assistance. For the service production, collaboration between municipalities is of great importance, because they are not able to provide all services by themselves. Private service producers are as well filling the gap between supply and demand in social and health care services. Municipalities have service contracts with private sector.

Old age groups are the main users of social and health services. The costs of social and health services for an individual begin to increase from 75 years of age. Family caregiving has an important role in decreasing the costs of social and health care. The development of family caregiving is an important topic in general discussions among social and health care. In principal, Finnish citizens have equal rights to support. Government sets the financial framework but municipalities can autonomously decide the amount of funds they afford to allocate for support. This has led to inequality in the provision of financial and other services between municipalities.

The need of services has been studied thoroughly during the past ten years when the resources in social and health care have decreased. In 1990s various indicators were increasingly brought to use in the assessment of service needs. On average long-term institutional care includes very few clients who are not in the most demanding class category. Some 40 % of long-term health centre in-patients need special rehabilitation or are clinically complex. Most persons in long-term institutional care have impaired cognitive and physical functioning and a great need for help. While the number of client beds in institutional care have been reduced and only the clients in need of the most de-

manding care can be cared for in institutions, the pressure toward family caring is increasing.

In Finland there is a minor group of about 125,000 alive World War II veterans. Municipalities are compensated for their services. The forms of compensation under the Military Injuries Act consist of annuities with supplements, supplementary annuities, medical treatment costs, housing modifications, rehabilitation and institutional care as well as burial allowances, assistance pensions and lump-sum compensations. In addition, the municipalities are compensated for at least 25 per cent of the costs of home services provided for disabled war veterans, housing services, support for care by near relatives as well as rehabilitation and institutional care. Within veterans' services, compensation is also paid for the rehabilitation of disabled war veterans' spouses and widows / widowers from the State budget allocations.

After the state subsidy reform in 1993 social and health organizations have gone through changes meant among other things to readjust available resources. Currently collaboration is being developed among social and health care sectors in municipal services. The aim is to make the services better meet homecare demands due to decreased supply of institutional care.

Compared to other European countries, the specific issue in Finland is the low number of migrants, which may change though due to increasing transfer of labour force in European Union and the impending shortage of working age people.

1 Profile of family carers of older people

There are no all-inclusive statistics of family carers in Finland. We can get some kind of information about the situation of family caregiving by estimating the amount of older people in need of help. The number of persons whose care depends on support for informal care has continuously increased (Vaarama et al. 2003a).

Family carers can apply for support for informal care which is defined in social welfare decree. The support for informal care is intended to all family caregivers regardless of the age of person in need care. There is reliable statistical information of the amount of family carers who get this support, their gender, relationship etc.. However, specific information of 65 year and older family carers is lacking in part. This national background report does not therefore cover the whole country due to missing data. Informal care plays an important role in the caring of old people. Over 90 % of older people live at their own homes by themselves or supported by a relative of significant others. More than one third of people 60 years or older get some kind of help (Vaarama et al. 1999a).

1.1 The number of carers

The number of persons aged at least 65 years and getting support for informal care between 1998 and 2002 is presented in table 2. In 2002 the number was about 2 % of 65-year-old population (Vaarama et al. 2003a).

Table 2: Support for informal care 1998-2002, clients aged over 65 during the year

Year	Total	65-74	75-84	85+	65+, % of 65 or older	75+, % of 75 or older	85+, % of 85 or older
1998	12,779	3,684	5,386	3,709	1.7	2.8	5.0
1999	13,186	3,784	5,538	3,864	1.7	2.8	5.0
2000	14,355	4,055	6,142	4,158	1.8	3.0	5.3
2001	15,920	4,580	6,885	4,455	2.0	3.2	5.6
2002	17,032	4,745	7,625	4,662	2.1	3.4	5.8

Source: Kauppinen et al. 2003, 67.

Between 1998 and 2001 the number of carers of at least 65-year-old people have increased from 6,493 to 8,925 persons (Pocket information booklet of social and health services 2003).

1.2 Age of carers

The age distribution of carers has been given in the report concerning support for informal care within social services. This report concerns only those 18 268 family carers who got support for informal care, and the figures include also persons taking care of people younger than 65 (Vaarama et al 2003). In table 3 the share of age groups of main carers are shown. The amount of carers 50 years or older is increasing. The share of carers 50 years or younger has decreased from 40 % to 27 % between 1994-2002 (Vaarama et al 2003b).

Table 3: Age groups of main carers in private homes

Age of main carer (incl. all carers)	Proportion
18-49 years	30 %
40-64 years	33 %
> 65 years	39 %

Source: Vaarama et al 2003b.

1.3 Gender of carers

There is no official statistical information of the gender of carers, but it is well known that the majority of carers are women. According to the report of the support for informal care the share of male carers is 25 % and female 75 % in 2002 (Vaarama et al. 2003b, 26).

1.4 Income of carers

The support for informal care is available for family carers through social welfare within each municipality. However, the municipalities may limit the amount of the support according to their financial situation. In 2002 the average size of the allowance in the whole country was EUR 287,89 (Vaarama et al. 2003a, 3). The minimum is EUR 229,29 in 2004 (Ministry of Social Affairs and Health, family care 2004, www.stm.fi). There is no statistical information of the financial situation or income of the family carers who in addition to family caregiving work outside the home.

1.5 Hours of caring and caring tasks, caring for more than one person

There is no available information about the hours spent in caring tasks or about the number of carers devoting time for more than one person. The situations are context-bound but in general family caregiving is a full-time job.

1.6 Level of education and / or Profession / Employment of family carer

The level of education of people aged 30 years or over by age in 2002 is shown in table 4. It is lower with 45 years or older persons than with younger persons (Ilmarinen 1999, 111). These figures concern the whole population. No specific data of family carers exist.

Table 4: The level of education by age in 2002 (%)

	30-44	45-54	55-64	65-74	75-84	85+	30+[1]	(N)[2]
Men								
Primary level / school	18.2	28.2	50	70.6	72.7	80	41.5	(1,273)
Secondary level	50.2	37.6	29.7	20.5	16.7	14.8	36.0	(1,157)
Higher level	31.7	24.3	20.4	8.9	10.6	5.2	22.4	(728)
Total	100	100	100	100	100	100	100	(3,158)
Women								
Primary level / school	13.8	34.3	53.5	72.4	77.2	79.8	39.5	(1,710)
Secondary level	35.7	29.9	24.6	17.6	13.9	11.0	28.0	(1,028)
Higher level	50.5	35.7	21.8	10.0	8.9	9.1	32.7	(1,171)
Total	100	100	100	100	100	100	100	(3,909)

Note: The figures have been extracted from the nationally representative sample which included 8,028 persons aged 30 or over in the Health 2000 Study carried out in 2000-2001.
[1] age-standardised
[2] unweighted number of observations
Source: Martelin et.al. 2002, 18.

In table 5 information about the occupation prior to retirement for people over 65 years of age is shown. In 2001 the main occupation categories before retirement among men were industrial work (38.4 %), office work or services (33.5 %) and agricultural work (24.3 %). The majority of women had been working in office work or services (48 %) and agricultural work (24.9 %). The proportion of persons working in agriculture has declined during the follow-up (1993-2001) in both men and women (Sulander et al. 2001).

Table 5: Main occupation before retirement age among persons aged 65-84 years in 1993 and in 2001(%)

Men	1993	2001
Agricultural work	31.5	24.3
Industrial work	39.4	38.4
Office work or services	26.8	33.5
Other	2.3	3.7
Women	**1993**	**2001**
Agricultural work	34.2	24.9
Industrial work	13.5	13.4
Office work or services	31.6	48.0
Housewife	19.9	12.2
Other	0.8	1.5

Source: Sulander et al. 2001.

1.7 Generation of carer, Relationship of carer to OP

According to the report of the support for informal care the main carers were spouses (43 %) and children (22 %) (Vaarama et al. 2003, 27).

1.8 Residence patterns (household structure, proximity to older person needing care, kinds of housing etc.)

The information of residence patterns of carers and their relatives is not available. In the following general information of the living conditions of older people is presented. More information is available at chapter 7.1.1.10.

The number of older people living alone has increased in Finland. Every other of the 65+ households and nearly 60 % of the 75+ households consisted of one person in 2000 and in 2002. Living alone and age are the key indicators of service need. In addition, the type of accommodation and its level of equipment is associated with the potential need of service. On average, the Finns live in well-equipped dwellings (Kauppinen et al 2003, 50, Päätalo et al. 2003).

In 1988 there were some 300 000 households (14 % of all households) where help from other people was needed (including all age groups and older person, handicapped or person with chronic disease) (Sihvo 1989, 47). On the other hand, in 1998 it was estimated that 133 000 persons over 60 years of age needed help with activities of daily life (Vaarama, Kaitsaari 2002). (More in Chapter 7.1.1.4)

1.9 Working and caring

The number of carers aged 65 or older has increased since 1994. The share of family caregiving as a main occupation was 10 %, 55 % of carers retired and 8 % were unemployed. 18 % of carers worked in full-time and 6 % in part-time jobs. Only 1 % had leave of absence from their normal work (Vaarama et al. 2003, 29). The figures include people caring for persons of all ages, and the specific figures concerning family carers of older people are not available. The development of day care for older people has, however, enabled family carer to work outside home.

1.10 General employment rates by age

The employment rate for men below 55 years of age has been quite stable over 30 years. The participation rate of men at the age of 60-74 was dropped almost 40 percent since 1970 (Ageing and Employment Policies Finland 2003). The employment rate of people in the age group 55-64 was 47.8 in 2002 (Employment policy strategy 2003).

The employment rate in women aged 55-59 has increased significantly over the past few years. It is now higher than in their male counterparts. The participation rates in women aged 50-64 was about 65 % in 2002. The incidence of part-time work among older female workers (age 50-64) was 15.9 % in 2002 and 11.6 % among younger female workers (age 25-49). 27.3 % of female and 25.5 % of men were older workers (aged 50+) (Ageing and Employment Policies Finland 2003). In general there is no difference between genders in the employment rates (Employment policy strategy 2003).

1.11 Positive and negative aspects of care-giving

Depending on the extent of voluntariness family caregiving can be a source of joy or a cause of anxiety. Spending long periods of time bound to a person who needs a lot of help and care may cause a lot of strain, which can have a negative effect on the quality of life and the relationship between carer and the person to be cared for.

Below a qualitative study of family caregiving is introduced to give examples of the experiences of the carers. Study of the caring relative´s experience of dementia was carried out in 1996 at the University of Tampere. The data consisted of 159 stories of being a relative to a demented person. The stories included 56 accounts from wives, 48 from daughters and daughters-in-laws and 17 from husbands. The majority of the stories were written in the form of a narrative with a plot. Many of them also described life before dementia. The writers had both positive and negative experiences of health care and of being a carer. The content of the stories included problems of everyday life, change of the time structure of every day life and the change in relationship between the

carer and the person who received care. Many of the respondents perceived the information they received about the disease inadequate. Positive was that they got to know the diagnosis. Temporary care did not benefit the patient but it did help the carer. The carers felt joy and happiness about having the spouse care for them. They also felt guilty, tiredness and fear of future, sadness and depression of the situation (Jylhä et al. 1996).

There is not much knowledge of family carer's health problems in Finland. The number of older people among family carers is, however, increasing, and according to earlier experiences, the support for older family carers should be focused on their health status (Hännikäinen 1998).

The elderly abuse or neglect by the family caregivers in Finland is lacking of data.

1.12 Profile of migrant care and domestic workers (legal and illegal). Trends in supply and demand

There is no information of the total number of migrant care workers for older people in Finland. Until 1970s Finland was a country of emigration. Majority of the share of immigration consists of people moving back to their home country. The share of foreign people in Finland is only about 1 % and people born outside Finland about 2 %. The share of those who have moved from the former Soviet Union is three times larger than the number of emigrants from Nordic countries. One fifth of immigrants are refugees (Employment policy research 2002).

1.13 Other relevant data or information

no other relevant data or information provided

2 Care policies for family carers and the older person needing care

2.1 Introduction: Family ethics and expectations – the national framework of policies and practices for family care of dependent older people

2.1.1 What are the expectations and ideology about family care? Is this changing? How far are intergenerational support and reciprocity important? Do minority groups have different ideologies?

The target in our society is that older people may live in their own homes as long as they wish, and families are expected to take more responsibility for their older members in need of care (Heikkilä et al. 2003). The importance of informal care is emphasized, because it reduces the pressure for institutional care (Vaarama et al. 2003a). Quite recently the administrator set up by the Ministry of Social Affairs and Health has given a proposal for including the carer-status as part of the social and health services (Ministry of Social Affairs and Health 13.10.2003). Read more about this in chapter 6.

In 2002 the Ministry of Social Affairs and Health set up the National Development Project in the Field of Social Welfare. The aim of the project was to outline a long-range development programme to ensure the balanced and controlled development of the social welfare field. In proposals concerning the improvement of the availability and quality of services special attention was paid on services for families with children and older persons (Heikkilä et al. 2003).

Recently the strategies of old age policy have been formulated in municipalities. The purpose of these strategies is to set frames for planning services for older people. For example, in the city of Jyväskylä (with about 80 000 inhabitants, in central Finland) family caregiving has also been noted in the service strategy. Adequate financial and social resources are expected to provide support for carers and service vouchers will be introduced to “granny-sitting”. The same strategy has set a target with the aim that at least 3 % of the 75+ city dwellers could live at home in family caregiving. Support groups, vacations and supervision of work for carers will be available (The strategy of old age politics in the city of Jyväskylä for years 2002-2010, www.jkl.fi).

In Finland there are two minor groups with a special status: Romani and the Laplanders. There are some 7,000 Laplanders in Finland, mostly in the northern part of the country. Four municipalities in northern Finland (Inari, Utsjoki, Sodankylä ja Enontekiö) will receive a 10 % raise in the state subsidy for growing services in their own language (http://pre20031103.stm.fi/). The estimated number of Romani in Finland is 10,000, and 3,000 Finnish Romani live in

Sweden. Among the Romani the support of the family is very strong (http://pre20031103.stm.fi/).

2.1.2 Are there any legal or public institutional definitions of dependency – physical and mental? Are these age-related? Are there legal entitlements to benefits for caring?

There is no legal definition of dependency. The term dependent is used meaning that a person is disabled and needs another person's help for daily activities. The need of help is defined on the basis of functional ability which is assessed with various instruments. The dependent person's need of care is categorized into levels for the definition of support needed (Vaarama et al. 2003a). Cognitive decrement e.g. dementia, may lead to dependency of other people and need of a statutory guardianship which is defined in the legislation.

2.1.3 Who is legally responsible for providing, financing and managing care for older people in need of help in daily living (physical care, financial support, psycho-social support or similar)?

According to the Constitution of Finland there are basic- and human rights, which the state is expected to fulfil. This is the basis for the development of care and services for older people (Vaarama, Kaitsaari 2002). Municipalities are responsible for providing the care within the framework set by government. The general target of elderly policy is to promote the welfare of older people, their autonomous life and good care. The main values are equality, right of selfdetermination, financial independency, social integration and safety (Old age policy 1999). The ways of implementing age policy include policies of housing, pension and other prevailing welfare and social and health services. The different departments of the municipalities share the responsibility for offering prerequisites for good life for older citizens.

In Finland there are several laws, where e.g. the social and health services and the rights and treatments of clients are defined (e.g. Primary Health Care Act 66 / 1972, Act on the Status and Rights of Patients 785 / 1992, Social Welfare Act 710 / 1982). According to these laws the client has the right to the good quality of social, health and illness care and the right to take part in planning his / her care (Vaarama et al. 2002).

2.1.4 Is there any relevant case law on the rights and obligations of family carers?

There is no law of family caregiving as such in Finland. However, the support for informal care, which is organized by municipalities, is defined in the Social Welfare Act. A municipality has the right to decide the level of quality of services and the amount of the allowances paid. In the Social Welfare Act, it is clearly explained what the agreement of family caregiving has to include (e.g.

fee, provision of leisure time for the carer and duration of care). According to Social Welfare Act, support for informal care includes allowance for the carer (relative or some other person) and services, which are specifically defined in the client´s care and service plan. Support for informal care is available, if a person needs care due to decreased functional capacity, illness, handicap or similar reasons, which can be cared for at the home of the person in need of care. In some cases the care can also be arranged at the carer´s home.

Since 2002 the family caregiver, who receives the support for informal care has the right to have two days off per month, while the municipality has a responsibility to arrange for the care for the dependent person. Family caregivers are also insured against injuries by the municipality (www.stm.fi).

2.1.5 What is the national legal definition of old age, which confers rights (e.g. pensions, benefits, etc.)

In Finland the national legal definition of old age is 65 years. That gives a person living in Finland right to apply for national pension. There are two pension systems in Finland which complement each other. Employment pensions linked to past employment and national pensions linked to residence in Finland. The national pension provides minimum allowance for subsistence, when the person has no or only minor earnings pension. Both systems include a wide range of retirement benefits for specific contingencies: old-age / early old-age pension; disability pension / rehabilitation subsidy; individual early retirement pension; unemployment pension.

There are two types of age pensions: old-age pension and early old-age pension. Both under the national pensions and the employment pension legislation. According to pension reform be introduced in the beginning of 2005, transition from working life to old age pension will become flexible varying between 62 and 68 years of age.

2.2 Currently existing national policies

2.2.1 Family carers

In the municipal service system the target share of care giving provided at homes is expressed in the strategies of old age policy. The support for informal care is guaranteed by the Social Welfare Act, but the municipalities themselves may decide the criteria for the support, which normally are based on the dependent's need estimated by his / her functional assessment (see chapter 2.1.2). In March 2004 the Ministry of Social Affairs and Health released a report consisting a development programme for family carer's status. (see chapter 6.1)

2.2.2 Working carers: Are there any measures to support employed family carers (rights to leave, rights to job sharing, part time work, etc)?

In Finland there are no regulations concerning employed family carers except in a few special cases. After a ten-years´ working history the employee may take job alternation leave up to one year from his / her job and this can be used for family caring among other things. Job alternation leave is an arrangement between the employer and employee, which enables the employee to take leave from working duties. The employer is obligated to find a substitute from the unemployment registry, to take care of the duties during this time. When participating in job alternation leave, a person is entitled to receive financial support. The support covers 70 % of the unemployment allowance the person would receive if he / she became unemployed. Should the need arise, it is also possible for the employee to work for 60 % of the full working hours according to this arrangement.

2.3 Are there local or regional policies, or different legal frameworks for carers and dependent older people?

After the state subsidy reform of 1993 municipalities have been free to decide the coordination of their services (Kauppinen et al. 2003), which are available depending on their economical situation. Recently municipalities have been forced to reduce their services, e.g. day hospital activities, due to their low economical situation. However, in principle the basic services are the same for every Finnish citizen.

2.4 Are there differences between local authority areas in policy and / or provision for family carers and / or older people?

As it has already been mentioned, municipalities can decide the amount of support for informal care. Municipalities with high proportion of older people and rapid increase of older population use a relatively high amount of money for family care compared to municipalities with a slower rate of increase (Luoma et al. 2003, 55).

3 Services for family carers

Services for family carers	Availability			Statutory	Public, Non statutory	Voluntary		Private
	Not	Partially	Totally			Public funding	No public funding	
Needs assessment (formal – standardised assessment of the caring situation)			X[1)]	X				
Counselling and Advice (e.g. in filling in forms for help		X[2)]			X			X
Self-help support groups		X[3)]			X	X		X
"Granny-sitting"		X[4)]			X	X	X	X
Practical training in caring, protecting their own physical and mental health, relaxation etc.		X			X	X		
Weekend breaks		X		X				
Respite care services		X		X				
Monetary transfers		X		X				
Management of crises			X	X				
Integrated planning of care for elderly and families (in hospital or at home)			X	X				
Special services for family carers of different ethnic groups		X			X	X		
Other								

In principle, most of the services for family carers are available for all if they have been defined statutory. In reality there is variation due to the economical situation of municipalities. Therefore it may not be appropriate to mark services as totally available.

1) Needs assessment (formal-standardized assessment of the caring situation): Personal care and service plan is made for each client in home service and home nursing, and it has been guaranteed by legislation that such a plan should be made for the clients with the amount of allowance based on the level of aid needed.

2) Counselling and advice (e.g. filling in forms for help): In different kinds or projects targeted to family care there is also help available for counselling. Primarily home help and home nursing work do not include filling in forms, but occasionally this can be done. In some bigger cities there are information centres or counselling points, e.g. in Tampere the counselling point offers information of services for older citizens and counselling for everyday life. In the city of Helsinki, Senior Info, offers information and counselling to elderly persons about social and health services, housing, cultural activities and leisure.

3) Self-help groups: Associations for family carers and different kinds of projects arrange peer support groups, which are mostly financed by RAY (Finland's Slot Machine Association). Municipalities organize peer groups as well.

4) Granny-sitting: Associations of family carers offer temporary help, and the individual plan for service and care plan made with a municipality may also include granny-sitting.

3.1 Examples

3.1.1 Good practices

no data available

3.1.2 Innovative practices

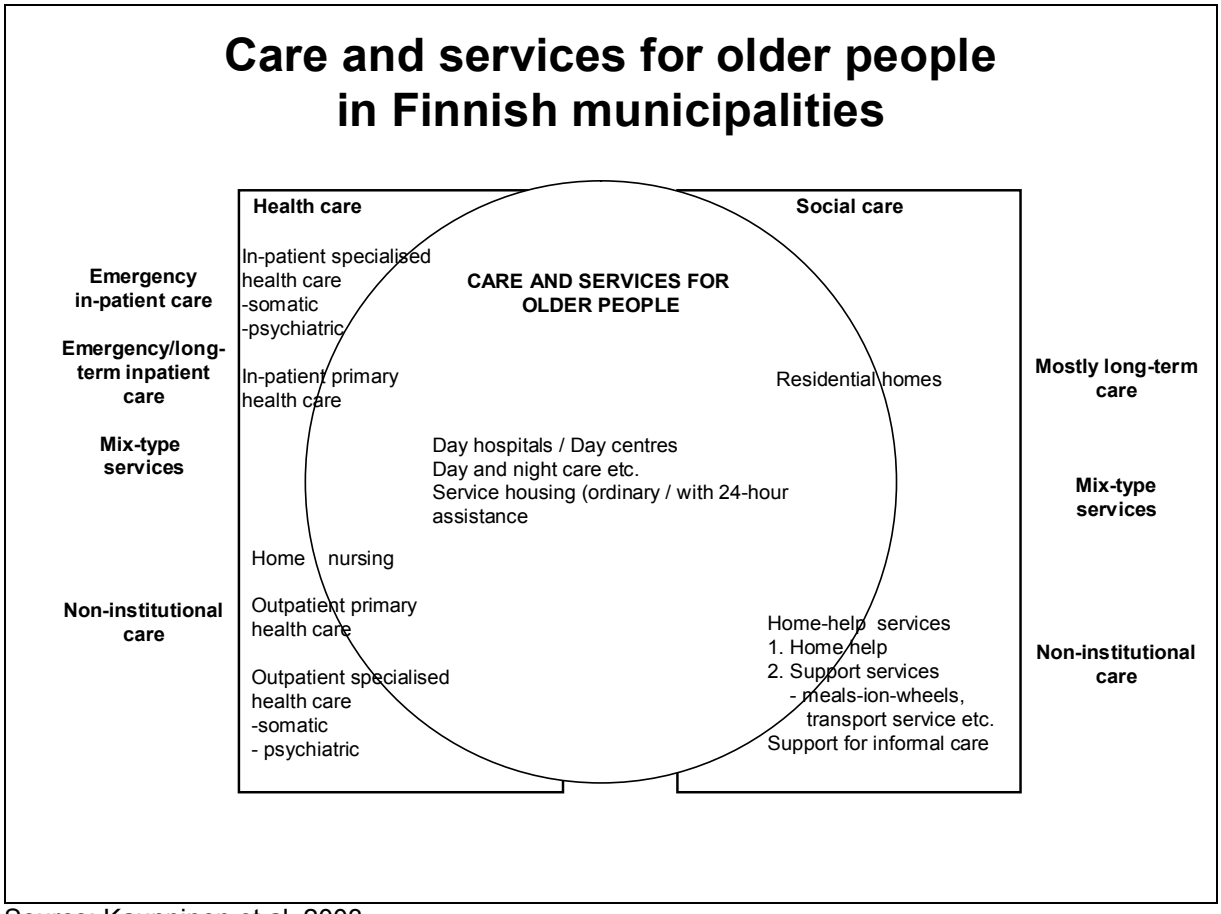
Four big associations The Association of Care giving Relatives and Friends, The Association for Old Age and Neighbour Service, The Central Union for the Welfare of the Aged and The Central Union for the Alzheimer Disease organize dozens of different projects per year together with the local associations. The purpose of these projects is to support caregiving families. In the following some of the projects are listed:

- ”Verrokki”
- Combining Work And Family Caregiving - Project
- Charitable Collection To The Care Givers
- Carmen
- Advancing the caregivers’ well-being
- Initial support for family caregiving
- Development of individual ”granny-sitting” for families
- Development of the support methods for exhausted family carers
- Improvement of the quality of life of carers and dependent persons
- Intervention of tailor-made individual services for caregiving families
- Older people as caregivers and spouses - intervention

4 Supporting family carers through health and social services for older people

4.1 Health and Social Care Services

Services for older people aim at providing support in the daily activities, improving the opportunities for social integration and ensuring appropriate caring and nursing. In Finland services for older people are provided as both social and health care. In- and outpatient care in primary health and specialised health care are provided in the area of health care. Emergency medical care is mainly provided in university and central hospitals and also in health centres. Long-term institutional care, mixed-type and non-institutional services for elderly people are provided both in social and health care: institutional care at health centre wards and in old age homes, day-hospital services in health centres and hospitals, day-centre activities in service houses etc. Home care is provided by home-help service units or home nursing units. They are provided either together or separately. In Finland 13,4 % of over 65-year-old people (106 800 persons) were receiving social and health services on a regular basis at the end of 2002 (Kauppinen et al. 2003, 21, 54).



Source: Kauppinen et al. 2003.

Care services needed by older people can be divided in to institutional (described in more detail later) and open care services. The most significant services among open care are home help, supportive services and home nursing. The target of older people´s care is to provide opportunity for an autonomous life at one´s home, in a familiar environment as late as possible, which is supported by with professional social and health care services. Home help is based on the individual care and service plan, and according to the Ministry of Social and Health Care (The Association of Finnish Local and Regional Authorities 2004), the need for services and compensation methods should be used as criteria for homecare. The care and service plan is also made, if a family caregiver needs help in the caring work. In practice, availability of services regulates supply. During the 1990s institutional care has been diminished and nursing home care is more often replaced by service housing or service housing with 24-hour assistance (Luoma et al. 2003).

Support for informal care belongs to those services which municipalities are responsible for, on the basis of Social Care Act (710 / 1982). In 2002 support for informal care was granted to 26,210 persons in Finland, which was 10,000 persons more than in 1994. Most of the persons in care were 65 years or older. In addition to the support for informal care the carers are eligible for same services with the rest of the population. The Ministry of Social and Health set up the administrator in 2003 to make a proposal for developing the status of family carers as a legislative part of the municipal services (Bulletin of the Social and Health Ministry 291 / 2003), in which case there would be changes in basic health care for the family carers.

The municipalities were given a greater freedom in organising social and health care services in the state subsidy reform of 1993 (Act 733 / 1992). The reform changed the nature and importance of guidance (Kauppinen et al. 2003, 25).

4.1.1 Health services

The administrative areas where health care personnel work in close contact with each other within municipalities are required to provide the basic health care services. In addition to medical services, home care (home help and home nursing) is arranged within these administrative areas. By the end of the year 2000 about 66 % of the Finnish population were covered by this system. Over 600 health care centres all over the country offer versatile local services. A system which enables a personal physician and a nurse for clients has made it possible to increase the availability of health care services in the municipalities (Report in Social Affairs and Health 2002, 53).

4.1.1.1 Primary health care

Basic health care has the responsibility in promoting health, preventing health problems, early diagnosis and treatment of illnesses as well as rehabilitation. Basic health care services are the same for every Finnish citizen and family caregivers are not offered any special services. Instead, several municipalities arrange senior clinic activities, which offer physician examinations for 75-year-old people.

Recently, homecare teams have been formed in municipalities and they provide very often both home help and home nursing. Both are chargeable services. Physicians´ house calls are available, and also samples for laboratory tests can be collected at home and auxiliary equipment are provided. When there is need for them, physiotherapists' and social workers' visits are also available at home. In addition, workers in parishes and volunteer workers make home visits. Oral health care services and chirobody is not available at home, except in special cases on client´s own cost. In a few larger cities, services of homehospital type are offered for people in need of intravenous antibiotic treatment or suffering from asthma (Hujanen 2003, 32).

Tables 6-8 show information of home care (home help and home nursing) among clients aged 65 years and older at the end of years 1997, 1999 and 2001.

Table 6: Clients aged 65 years and older in home-help and home-nursing at the end of the years 1997, 1999 and 2001 (number and proportion of persons aged 65 or older).

Homecare clients	1997 (%)	1999 (%)	2001 (%)
65-74 yrs	1,416	10,297	10,122
75-84 yrs	23,288	25,007	25,288
85+	13,743	16,107	16,943
Total	47,447 (6.3 %)	51,411 (6.7 %)	52, 353 (6.6 %)

Source: Pocket information of social and health services 2003.

Table 7: Table 7: Clients receiving regular home care by type of service at the end of the years 1997, 1999 and 2001 (number and proportion of persons aged 65 or older)

Service	1997 (%)	1999 (%)	2001 (%)
Only home-help	21,474 (42.3 %)	22,215 (43.2 %)	24,590 (47.0 %)
Only home nursing	12,503 (24.7 %)	12,036 (23.4 %)	11,843 (22.6 %)
Both home-help and -nursing	14,679 (29.0 %)	17,160 (33.4 %)	15,920 (30.4 %)
Total	48,655 (100 %)	51,411 (100 %)	52,353 (100 %)

Source: Kauppinen et al. 2003, 64.

Table 8: Physician visits in primary health care in 1994 and in 2001 among clients aged 65 years or older

Year	Total 65+	65 and over (%)	65-74	75-84	85+
1994	1767,864	2.5	994,351	617,700	155,813
2001	2113,891	2.6	1075,944	808,913	229,124

Source: Kauppinen et al. 2003, 69.

4.1.1.2 Acute hospital and Tertiary care

Depending on the type of illness, hospital treatment is offered in local health centre hospitals, in specialized units of Central Hospitals, or in Medical University Clinics. In the biggest health centre hospitals there is at least one geriatrician, but geriatric wards as such are not very common. Mostly in health centre or city hospitals older people are treated on the same wards with other clients of different ages.

Geriatric rehabilitation aims at restoring and maintaining the highest possible functional status of older people in spite of diseases and disabilities, and thus increases the autonomy and quality of life. In hospitals there are geriatric rehabilitation teams consisting of a physician, one or more nurses, a physiotherapist, an occupational therapist and a social worker. If there is need for it a neuropsychologist, a speech therapist, a chiropodist and a dietician can also be brought in to this team (Valvanne et al. 2001).

Secondary rehabilitation is offered by the institution, where the client resides. In addition there are rehabilitation centres, where rehabilitation courses are arranged for different age and disability groups. Geriatric know-how has rapidly increased during the last few years. In 2002 there were 97 geriatrician (Stakes and National Authority of Medicolegal Affairs 2003). The wards for psychogeriatrics and old age psychiatrics are located in each of the five University Hospital.

In the following, table 9 shows figures of inpatient care by speciality.

Table 9: Table 9: In-patient health care by speciality in 1995, 1999 and 2002 among persons aged 65 years or older (percentages in different age groups).

All specialities				
Year	**Clients / year**	**of 65 and over (%)**	**of 75 and over (%)**	**of 85 and over (%)**
1995	238,501	32.6	44.6	58.5
1999	241,890	31.5	43.0	58.5
2002	237,243	29.7	40.4	57.0
General practice				
Year	**Clients / year**	**of 65 and over (%)**	**of 75 and over (%)**	**of 85 and over (%)**
1995	98,624	13.5	23.3	38.6
1999	113,808	14.8	25.2	42.7
2002	115,349	14.4	24.1	42.2
Somatic specialities				
Year	**Clients / year**	**of 65 and over (%)**	**of 75 and over (%)**	**of 85 and over (%)**
1995	183,413	25.0	31.2	33.7
1999	181,796	23.7	29.3	32.6
2002	176,671	22.1	27.4	31.9
Psychiatric specialities				
Year	**Clients / year**	**of 65 and over (%)**	**of 75 and over (%)**	**of 85 and over (%)**
1995	4,924	0.7	0.7	0.7
1999	4,429	0.6	0.6	0.5
2002	4,187	0.5	0.5	0.5

Source: Kauppinen et al. 2003, 74.

4.1.1.3 Are there long-term health care facilities (includes public and private clinics)?

Social and health care services have undergone a structure change in the 1990s. The share of institutional care has diminished and service housing grown. The aim is to have 90 % of people aged 75 year and older live at their own homes autonomously or with the help and support from social and health care services or relatives or significant other people. It has been estimated that 10.3 % of the 75-year-old population receives care services 24 hours a day (Kauppinen et al. 2003). Long-term health care services are arranged in health centre nursing service.

The main alternatives for the provision of institutional care for the elderly constitute service homes, homes for the elderly and health centre hospitals. They

differ in care intensity and in division of financial responsibility between clients, municipality and the Social Insurance Institution. In addition, there are veterans' service houses which offer, among other services, long-term care for World War II veterans. They are funded by foundations, but also supported financially by government.

There were over 11,600 persons aged 65+ and 9,900 persons over 75 years in long-term in-patient care in health centres at the end of 2002. The client number has slowly decreased since 1995. One in every six persons over 65 (131,000 clients) and one in four over 75 (98,500 clients) has been in in-patient care in health centres during 2002 (Kauppinen et. al. 2003, 73).

In tables 10 and 11 the number of clients in institutional care during 1999-2001 is shown.

Table 10: Institutional care of health care in 1999-2001 among persons aged 75 years or older (number and % of total number of 75+ population)

Clients in long term care at the end of the year	1999 (%)	2000 (%)	2001 (%)
All institutional care in health care	19,01	18,984	18,797
amount of clients 75+	12,151 (3.7 %)	12,121 (3.6 %)	12,094 (3.5 %)
Institutional care in health centre	14,965	14,873	14,740
75+	11,661	11,580	11,520
Psychiatrics	3,478	3,412	3,236
75+	174	167	153
Other hospitals	658	699	821
75+	316	374	417

Source: Pocket information booklet of social and health services 2003.

Table 11: Clients aged 65 and older in long-term care in health centres at the end of the years 1995, 1999 and 2002 (number and proportion of 65+ population)

Year	Total 65+	65-74	75-84	85+	65+, %
1995	13,219	2,084	5,483	5,652	1.8 %
1999	12,386	1,863	4,939	5,584	1.6 %
2002	11,645	1,702	4,811	5,132	1.5 %

Source: Kauppinen et al. 2003, 72.

4.1.1.4 Are there hospice / palliative / terminal care facilities?

A person in terminal care should be able to live the final phase of his / her disease in an environment he / she finds most pleasing and without strong symptoms and / or pains. During the past few years the share of clients in terminal

care has increased in nursing homes due to an attempt to decrease the use of hospital beds, when it is not necessary from medical reasons.

In the Finnish public health care system palliative care is not often separated from other care. The few centres specializing in palliative care are maintained by private foundations. Mostly palliative care is given in health centre hospitals, but it can also be arranged at home, if the person and his / her relatives so choose. In the case home help, home nursing (physician and nurse calls) and day hospital services are available.

4.1.1.5 Are family carers expected to play an active role in any form of in-patient health care?

The hospital personnel is responsible for basic and medical care. However, family carers usually want to take part in the client´s care during the in-patient period, and he / she can also participate in the planning of care. The family caregiver is a very important informant in the needs of the older client. Many family carers would like to have a more important role in the care of their relatives in in-patient care. Indeed, they may have valuable information of the problematic situation met already at home. However, the hospital personnel has the main responsibility for the provision of care.

4.1.2 Social services

Administrative areas with multiprofessional teams are providing the basic social care on local level. In principle, Finnish citizens have equal rights to social services. However, after the subsidy reform in 1993 municipalities have had more power in deciding the type and extent of services they offer. This has lead to regional inequality in service supply. In addition, some parts of the country are very sparsely inhabited and services may not be easy to reach.

4.1.2.1 Residential care (long-term, respite)

Long-term care, respite care and service housing are enacted in the Social Welfare Act. Institutional care is meant for people who need help and care in a situation, where care is not possible at home even with home help. Residential care covers service housing with 24-hour assistance, old-age homes and wards in health centres (see chapter 4.1.1.3.) (Luoma et al. 2003).

The purpose of respite care is to postpone the need for long-term care. Respite care can be acute, short-term or interval care. Interval care is well planned and regular care, usually providing a break for the family caregiver. It can be split into e.g. two-weeks period at home followed by two weeks at the old-age home.

In 2002, the average age of long-term clients in residential homes, service homes and service housing with 24-hour assistance was 82.2 years (from Registers for Social Welfare and Health Care). The average time of client-stay

in care was 835 days. The average age of older people in health centre, long-term inpatient care was 82.8 years and average stay in care 710 days (Kauppinen et al. 2003).

4.1.2.1.1 Basic data on % of > 65s in residential care by age group and type of residential care (sheltered housing, residential homes)

In 1999 7.9 % of 65-years-and-older people were in institutional care in Finland. This figure includes also clients in short-time care. The need of institutional care is estimated to decline due to increase in the functional capacity among people aged 65 years or older. An estimate for the need of institutional care is only 5 % among this population in 2030 (Luoma et al. 2003, 75).

Tables 12-14 show the share of people aged 65 or older living in residential care.

Table 12: Clients aged 65 or older in service housing at the end of the years 1998-2001 (number and proportion of 65+ population)

Age of residents	1998 (%)	1999 (%)	2000 (%)	2001 (%)
65-74 yrs	2,226	2,377	2,107	1,984
75-84 yrs	4,048	4,808	4,539	4,560
85+	2,737	3,580	3,358	3,391
Total	9,011 (1.2 %)	10,765 (1.4 %)	10, 004 (1.3 %)	9,935 (1.3 %)

Source: Pocket information booklet of social and health services 2003.

Table 13: Clients in old age homes and service housing with 24-hour assistance at the end of the years 198-2001 (number and proportion of population aged 65 or older)

Age of residents	1998 (%)	1999 (%)	2000 (%)	2001 (%)
65-74 yrs	3,457	3,595	3,477	3 640
75-84 yrs	10,129	11,003	11,228	12 046
85+	11,969	12,467	12,716	13 525
Total	25,555 (3.37 %)	27,065 (3.53 %)	27,421 (3.53 %)	29,211 (3.71 %)
Customs / year	46,700	48,806	49,795	52,111
Caredays / year	9,624,647	10,048,049	10,413, 690	11,146, 607

Source: Pocket information booklet of social and health services 2003.

Table 14: Clients aged 65 years and older in old age homes and service housing with 24-hour assistance at the end of the years 1998-2001 (number and proportion of 65+ population)

Age of residents	1998 (%)	1999 (%)	2000 (%)	2001 (%)
65-74 yrs	3,093	3,202	3,117	3,227
75-84 yrs	9,141	9,808	10,154	10,851
85+	11,119	9,808	10,154	10,851
Total	23,353 (3.08 %)	24,542 (3.2 %)	25,074 (3.23 %)	26,620 (3.38 %)

Source: Pocket information booklet of social and health services 2003.

Table 15 shows the information about new long-term clients.

Table 15: New long-term clients, who during the year have entered different kind of residential care in 1996, 1998, 2000 and 2002

	1996	1998	2000	2002
Residential home or service housing with 24-hour assistance				
Clients	10,401	10,382	11,792	12,369
Average age	80.8	81.5	81.2	81.7
Average need for care	3.8	3.9	3.9	4.0
Health centre (65+)				
Clients	12,632	12,874	12,552	12,231
Average age	82.1	82.2	82.4	82.4
Average need for care	3.8	3.8	3.9	3.9

Source: Kauppinen et al. 2003, 76.

Older people (65+) who had been receiving both home help and home nursing in 2001 had also had at least one period of care in service housing with 24-hour assistance, residential home, health-centre or hospital in-patient ward during 2001. About 60 % of older people who had been receiving only home help or home nursing, and nearly 70 % of those with support for informal care had had at least one period of care. Clients, who received support for informal care, used services in institutional care and service housing with 24-hour assistance clearly more than home-care clients (over 31 days during the year) and services of residential homes twice as much as clients receiving home-help services and home nursing on average. They had also a little bit more health-centre care days, but the same number of days in hospital in-patient care as other home-care clients (Kauppinen et al. 2003, 92-93).

4.1.2.1.2 Criteria for admission (degree of dependency, income etc.)

The admission criteria for institutional care in Finland are functional status, medical reasons, difficult home situation or living conditions. In the municipal

department of social and health care, a multiprofessional team is working for appropriate accommodation of older people, the agreement of which is made with the older person and his / her relatives (Valvanne, Noro 1999). In case institutional care is recommended for an older person, the physician is responsible for the decision.

After the change (connecting the organizations of social and health services) in the service structure of the social and health care sector, the share of institutional care has decreased and non-institutional services increased. Some of the municipalities have even closed old-age homes. At present institutional care is available only for the oldest and frailest people. Strategies for care and services for older people are very similar all over the country. Non-institutional care, mix-type services (=service housing and day centres or day hospitals), and institutional care form a continuum with unclear boundaries (Lehto 1997).

4.1.2.1.3 Public / private / NGO status

Most of the social and health services, such as home-help services, home nursing, service housing etc., are also available in private sector, which has expanded during the past few years. Private services are also bought by many municipalities in cases where they are not able to offer them through their own organizations. As an example, the Yrjö and Hanna –foundation offers services among respite or long-term care, meal and other services for older and handicapped people, as well as for those with problems in mental health. The foundation has services in different parts of Finland. In service housing all services are charged separately while in long-term care they are included in the client fee.

4.1.2.1.4 Does residential care involve the participation of carers or work with carers?

In case of in-patient period due to ill health of the person cared for, carer may many times want to take part in caring. Especially in long-term care the help of a relative is welcome because of personnel shortage.

4.1.2.2 Community care services (statutory coverage and whether aimed primarily at older people living alone or including support to family carers)

The most common services of older people are home-help service, meals on wheels, cleaning help, support for informal care, rehabilitation, auxiliarity equipment, health services and services for war veterans.

4.1.2.2.1 Home-help

Home-help is helping in daily activities, personal care, childcare and education (Social Welfare Act 1982 / 710, 20 §). A decreasing number of people is receiving home-help since early 1990s. Only people who most need help can get

both home-help service and home-nursing. The home visits are shorter than before (Lehto et al. 1997). The majority of home-help receivers are the oldest age groups and service housings (Luoma et al. 2003, 71). The probability for the use of public services is more than 20 percent higher between ages 75 to 80 years (Räty et al. 2003, 10). 84,300 older households were receiving municipally provided home help in 2002. That is 10.6 % of the population over the age 65. Based on different sources, it is possible to estimate that the municipalities account for nearly four fifths of all home help for older people. Private services provide the rest of home help. Municipally provided home help has declined since 1993 (Kauppinen et.al. 2003). In table 16 the number of households receiving home help among population aged 65 or older is shown.

Table 16: Households receiving home-help in 1998, 1999, 2000 and 2001 among people aged 65 years or older

Age	1998	1999	2000	2001
65-74 yrs	17,197	16,879	15,938	15,603
75-84 yrs	41,122	40,572	39,930	40,542
85+	26,300	26,832	27,280	28,065
Total	84,619	84,283	83,148	84,210

Source: Pocket information booklet of social and health services 2003.

4.1.2.2.2 Personal care

People may buy private services such as granny-sitting from caregiving associations. Bathing is one of the home-help services. Sauna-services are usually offered outside the residence, mostly in service centres for older people, and have a recreational purpose as well, as they provide contact to others.

4.1.2.2.3 Meal services

In many municipalities meal services are bought from private service providers. In urban areas people may get a warm meals even every day, but in the countryside meals are delivered to the clients frozen in packages to last for several days because of long distances. Living alone and availability of informal care are the criteria which increase the need for meals on wheels (Räty et al. 2993, 13). In some cases, it is still possible to have home-cooked food prepared by home-helpers at the client's home like before.

4.1.2.2.4 Other home care services (transport, laundry, shopping etc.)

Many grocery shops have home delivery nowadays. People may phone in their order or send it on via the internet and the shopkeeper will then deliver the groceries home. Sometimes it is possible that home-helpers take care of grocery shopping. Older people may also have laundry services produced by the municipality, but cleaning is only available from private service providers. It is possible to get different kinds of instruments at home, e.g diapers, canes,

wheelchairs. To help the older person live at home, a physical or occupational therapist visits him / her and decides together with the client the need for instruments or changes required at home, which are necessary to ease the everyday life. In Finland there is one special group, World War II veterans with over 25 % of disability, whose home services are covered in total by The State Treasury.

4.1.2.2.5 Community care centres

Community care centres offer day care for older people enabling the caregiver to rest or take care of e.g. instrumental activities of daily living. In community care centres older persons may get personal care (sauna and bathing, eating, rest) and participate in different kinds of activities. Day care is organized during the workdays, usually 1-5 times a week from 9.00 am to 3.00 pm, but in some places even until 7 pm. The meal service is also available for those who want to have a balanced diet. It is provided also for younger persons. Many times community centres are situated in connection with service housing.

4.1.2.2.6 Day care ("protective" care)

In some municipalities day hospital service is available. This service is, however, decreasing and the amount of community care centres is increasing. In addition, private associations have started arranging day care for older people. Services provided at service centres are recreational and physical rehabilitation and meals may be included (Räty et al 2003, 14). Persons who need more medical help are cared for in day care in hospitals.

4.1.2.3 Other social care services

Family caregivers are considered a very important part of old people’s care. In some municipalities attempts to ease their work have been made. For example in the rural municipality of Jyväskylä (a little municipality in central Finland with about 34 000 inhabitants) two persons of home help services are appointed for counselling in family care matters. Caregivers also get support from the Association of Care Giving Relatives and Friends and its local associations. The association arranges recreational and rehabilitation breaks for caregivers. Local Alzheimer Disease Associations offer support for caregivers including night care according to their resources.

4.2 Quality of formal care services and its impact on family caregivers: systems of evaluation and supervision, implementation and modeling of both home and other support care services

4.2.1 Who manages and supervises home care services?

The leader of home care services manages and supervises home care services. The person may have training in social or health care.

4.2.2 Is there a regular quality control of these services and a legal basis for this quality control? Who is authorized to run these quality controls?

The Ministry of Social Affairs and Health has given national recommendations for the development and quality of services for older people (2001). The recommendations concern all social and health services, but especially focus on home care, service housing and institutional care. The purpose of the recommendations is to give guidelines to the inhabitants of municipalities for the evaluation of the level of services offered. The Association of Finnish Local and Regional Authorities has carried out a project concerning the quality of old people care, the aim of which was to improve the quality of health care. However, municipalities can independently choose methods for controlling the quality of their services. A general way of evaluating municipal services is to repeatedly administer a questionnaire enquiring the clients' opinion on the availability, adequacy and functionality of the services.

4.2.3 Is there any professional certification for professional (home and residential) care workers? Average length of training?

In Finland the professional certification has a legal basis in social and health care. Usually the home and residential workers are nurses, physiotherapists and occupational therapists. The average length of training is 3.5 – 4.5 years. In addition there are nurses for basic care with 2.5 years of training. In social care there are professions with the same length of training as nurses. In Finland professional certification is defined by legislation. This means that only a qualified worker can get a permanent job.

4.2.4 Is training compulsory?

The Act of Professionals in Health Care and the National Authority for Medicolegal Affairs define the professional requirements for health care practice (http://www.finlex.fi). The Authority registers a person with a degree in health care, and gives them a legal right to practice a health care profession. The social care decree defines the education required from a professional social

worker. To some extent, there may be unqualified, temporary short-term workers with no professional training.

4.2.5 Are there problems in the recruitment and retention of care workers?

During the economical recession in the beginning of the1990s, the number of working people decreased. It has increased since but has not yet reached the same level. At the same time the number of old and frail clients, who need more intensive care has increased and work has become more demanding. There is a continuous leak of Finnish health care personnel to foreign labour markets, many times tempted also by better salary.

The number and adequacy of health and social care personnel has been surveyed nationwide in Finland. Continuation education is arranged for personnel for keeping up their know-how. The Ministries of Social Affair and Health and Education have set a coordination group with the aim of predicting the needs of education and labour force in social and health care. An additional target is to increase the student places in medical schools. The government has started being concerned of the adequacy of labour force and e.g. the Ministry of Labour recently coordinated the project aiming at promoting the work ability and maintaining the well-being at work (TATO 2003).

Among policy makers there is a concern of the large number of persons retiring from the work force in the near future It is estimated that 130,000 persons will retire in municipalities by 2010. 49,000-55,000 of them are working in social- and health care. To replace the retiring workers 18,300 workers are needed, because of the change in age structure, and an additional 6,300 to compensate the current shortage of workers (Luoma et al. 2003, 24).

4.3 Case management and integrated care (integration of health and social care at both the sectoral and professional levels)

4.3.1 Are family carers ' opinions actively sought by health and social care professionals usually?

Family caregivers have recently achieved a more important role and their opinions are more often taken into account. The Ministry of Social Affairs and Health has set up an administrator to develop the status of family caregivers. An aim is to include family carers as part of the community service system. The role of family caregivers as part of municipal services has been noted in municipalities.

Family caregivers have established a firm foothold in municipalities. A couple of new associations are founded every year, in some cases from the initiative of the municipality. By the associations, family caregivers get their voices

heard. The Association of Caregiving Relatives and Friends (http://www.omaishoitajat.com) is the parent organisation for family caregivers. In spite of this general positive attitude some family caregivers perceive that their work is not appreciated.

5 The Cost – Benefits of Caring

The GDP for the country? (Will be obtained from OECD and others centrally)

5.1 What percentage of public spending is given to pensions, social welfare and health?

Table 17 shows the percentage of social welfare cost of the GDP in 1990-2000. The percentage of social welfare from GDP will increase from 25 % in 2002 to 30 % in 2030. This will mainly be due to 6 % increase in pensions. The share of social- and health services provided by municipalities will increase 2 % of the GDP in 2000-2030. If there is no deterioration of growth in population and public economy, it is possible to organize the care services in the present manner (Luoma et al. 2003, 16).

Table 17: Social welfare cost of Finland in 1990-2000, % of GDP

	1990	1992	1994	1996	1998	2000
% of GDP	25.1	33.6	33.8	31.6	27.3	25.2

Source: Kautto, Moisio 2002, 333.

Old-age pension costs will explode with the increasing number of old age pensioners during the first ten years of 21st century. The life expectancy of older people will also increase and the future pensions will be better than before. (Luoma et al. 2003, 16.) The pension expenditures were EUR 15.2 million in 2001 (Parkkinen 2002) while in 1960 (converted to 2001 money) they were some one billion euros which was about 4 % of GDP. Pension expenditures have become 13 times higher during 41 years, because of the pensions paid by private employers (Luoma et al. 2003, 18).

Older age groups are the main users of social and health services. The costs of social and health services begin to increase from 75 years of age. During the last years 10 % of the GDP have been spent to the public and private social and health care services. In 1975 the corresponding figure was less than 7 % (Luoma et al. 2003, 42).

In 2001 health expenditure totalled EUR 9.5 billion (7 % of GDP). In comparing Finland to other OECD-countries, our expenditure has been among the lowest (Health service cost and funding in 2001, 2003).

Social expenditure in Finland totalled EUR 34.8 billion in 2001. It represented a 2.5 % increase in real terms compared with the previous years. The largest category of social costs has been various costs related to old age, including e.g. pensions. This category accounted for 31.6 % (EUR 11 billion) in 2001. Expenditure on old age has been increasing throughout the 1990s. It was 5 % higher in 2001 than the year before (Kauppinen et al. 2003, 101).

5.2 How much - private and public - is spent on long term care (LTC)?

Throughout the 1990s services accounted for some 10 % of expenditure on old age. During the decade, care in residential homes was the largest spending category in expenditure on services for older people (Kauppinen et al. 2003, 102). In table 18 expenditure on institutional care (including both public and private residential homes) for older people is represented.

Table 18: Expenditure on institutional care for older people 1990-2001 at 2001 prices, EUR million (public and private together)

	1990	1995	2001	1990-2001
Institutional care for older people	504	534	529	+ 5 %

Source: Kauppinen et al. 2003, 102.

Especially long term care for older people in health centres form an important part of the system of services for older people in Finland. Because of this these services should be taken into account in calculating the total cost on care and services for older people. Expenditure on health services used by older people can not be derived directly from the statistics, as no breakdown by age has been made in the accounts of all health services. Statistics of health expenditure and financing show that cost of health-centre in-patient care totalled EUR 936 million in 2001. Older people account for 90 % of health-centre in-patient care days, that is EUR 842 million (Kauppinen et al. 2003, 104).

5.3 Are there additional costs to users associated with using any public health and social services?

There are no additional costs for users in long-term care except the daily bed charge (see chapter 5.5) which includes all care the patient needs. For the outpatient health and social services which are shown in table 19 there are client fees. In addition, a so called special-fee patient can have quicker assess to the operation needed.

Table 19: Public outpatient health services, fees in 2004

The purpose of the fee	Client fee
Physician visits in primary health care	max 22 € / year or 3 x 11 €
Primary health care emergency	max 15 € / time (night time 20.00-8.00 and weekends)
Fine (not used with the visit to the physician) for not showing up for the appointment made	max 27 € (clients over age 15)
Dentist	max 7 € (+ costs of operations)
Special fee: every operation has to be paid separately (e.g. anesthesiology, laboratory-tests)	
Home nursing	Fee depends on whether care is temporary or regular. There is a monthly fee in regular home nursing. The amount depends on average weights and the size of household. Fee in percent varies from 11 to 35.

Source: The client fees of public health services in 2004.

5.4 What is the estimated public / private mix in health and social care?

The share of social and health services accounted for by enterprises and non-profit organisations has been increasing in recent years. It is currently representing as much as 20 percent of all social and health services. However, most private social services have been purchased by municipalities. Health services and home-help services are also provided privately. These services are subsidised from public funds. Private doctor fees and costs of medical examinations and treatments provided from private services are partly reimbursed under the National Health Insurance. Tax reductions are available for the purchase of domestic work (Kauppinen et.al. 2003, 23).

Recently 10 % of GDP have been used during the past few years in public and private health and social services (Parkkinen 2002, 30).

Home-help services and home nursing

It is difficult to estimate what is the comparison between public and private home-help services and nursing. Based on different sources it has been estimated that the municipalities account for nearly 80 percent of all home help for older people. Organisations provide some 13 % and enterprises just under one tenth of all home help for older people (Kauppinen et al. 2003, 62).

Service housing

A bit more than half of the service housing for older people is provided by private service providers (organisations and enterprises). Municipalities account for 45 %, organisations for 44 % and enterprises for 11 % (Kauppinen et al. 2003, 65).

Outpatient health services

Older people use also services of private physicians. At least 41 % of people aged over 65 years visited private physicians in 2002 (Kauppinen et al. 2003, 70).

Residential homes

About 89 % of care in residential homes for older people is arranged by municipalities. Organisations account for 11 % and enterprises for under one percent of care in such residential homes (Kauppinen et al. 2003, 71).

Institutional health care

In-patient care is mostly provided in hospitals maintained by municipalities or municipal federations (Kauppinen et al. 2003, 73).

5.5 What are the minimum, maximum and average costs of using residential care, in relation to average wages?

In table 20 the average costs of daily bed charge of residential care of older people in 2001 are presented. The costs are cheapest in service housing with 24-hour assistance and the highest are in the in-patient primary health care. The costs are not simply client costs but the total cost of bed charge funded from taxes (70 %), client costs (9 %) and governmental support (21 %).

Table 20: Average costs of daily bed charge of residential care of older people in 2001

Service	€ / daily bed charge, average
Service housing with 24-hour assistance	37,0
Residential home	96,9
Inpatient primary health care	135,9

Source: Hujanen 2003, 64-65.

Operating expenses of care in residential homes are shown in table 21.

Table 21: Care in residential homes by municipals in 2002, operating expenses

	Care days / year	operating expenses € / daily bed charge	Fees % of operating expenses	Net expenses € / daily bed charge
Whole Finland	7,368,589	98	18.4	75

Source: Association of Finnish Local and Regional Authorities 2004, www.kunnat.net.

Table 22: Price-, income level- and cost index (1995 = 100) in 1990, 1995, 2000, 2001

Year	Public spending, social services	Public spending, health services	Consumer price	Employees, income level	Hospitals, expense index
1990	84.8	86.8	80.4	85.4	84.9
1995	100.0	100.0	100.0	100.0	100.0
2000	112.1	113.5	114.3	119.1	112.3
2001	115.7	116.4	115.4	124.9	115.0

Source: Hujanen 2003, 85.

There is a EUR 590 upper limit for client fees of the municipal health services p.a. In principle when the upper limit is reached, outpatient services become free of charge for the client.

Client fees in public health services are presented in table 23.

Table 23: Client fees in public health service in 2004

Charge	Client fee
Daily bed charge in hospital	26 €
Daily bed charge in psychiatric hospital	12 €
Day / night care	daily bed charge 12 €
Long term institutional care	max 80 % of average wages, min. 80 € must be left for clients´ personal use
Special fee in hospital	daily bed charge max 104 €

Source: Client fees in public health services in 2004.

5.6 To what extent is the funding of care for older people undertaken by the public sector (state, local authorities)? Is it funded through taxation or / and social contributions?

Social and health services are mostly funded with public money, local and state taxes. The client fee is based on client's financial standing, and according to the Act on Client Fees in Social and Health Care (734 / 1992) the fee for institutional care may not exceed 80 % of person´s net incomes per month. The person must have at least EUR 80 for his / her personal expenses. In long-term care the spouse's economical situation is also taken into consideration, when the client's fee for care is determined. If the spouse´s pension per month is small, the fee will likewise be smaller.

In 2001, client and patient fees accounted for 9 %, state subsidies for 21 % and local taxes for 70 % of total expenditure on municipal social and health services. These figures include services not only for older people, but also the whole population. The amount of state subsidy paid to a municipality is deter-

mined by age composition, morbidity and employment rates among local inhabitants, etc. State contribution to service financing decreased significantly after the state subsidy reform but increased again in 2001 (Kauppinen et al. 2003, 105).

In 2001 the major financiers for the health service were municipalities (share 42.8 %). The other sources were the state with 17 % and Kela (The Social Insurance Institution of Finland)) with 15.8 % (Health service cost and funding in 2001, 2003).

5.7 Funding of family carers

Since 1982 the support for informal care has been funded. The support for informal care is allocated to the carer when a close person is in need of care because of decreased functional ability, illness or handicap. The care has to be administered at home. (Social Welfare Act 710 / 1982.) The support for informal care is taxable. Municipalities have the right to decide the amount of the support for informal care. In 2002 the average amount of allowance in the whole country was EUR 287,89 / month. There was variation in the distribution of allowances according to the number of inhabitants in the municipalities and the number of their residents aged 65 or more so that bigger municipalities paid higher allowances (Vaarama et al. 2003a). In 2004 the minimum allowance is EUR 229,29 / month (The Ministry of Social Affairs and Health, family caregiving in 2004, www.stm.fi).

5.7.1 Are family carers given any benefits (cash, pension credits / rights, allowances etc.) for their care? Are these means tested?

	Attendance allowance	Carers´ allowance	Care leave
Restrictions	Yes[1)]	Yes [2)]	Under discussion
Who is paid?		Family carer	
Taxable		Yes	
Who pays?		Municipal	
Pension credits			
Levels of payment / month		min 229,29 € in -04	
Number of recipients in 2002	see table 3	see page 11	

1) The family caregiver may choose service voucher or home services
2) If the carer needs home help for him- / herself the support for informal care is denied.

5.7.2 Is there any information on the take up of benefits or services?

An administrator in the Ministry of Social Affairs and Health has recently prepared a proposal for developing the status and aid mechanisms for the carers.

Presently it is possible to get services at home but services are not offered equally in different parts of the country. For example, the support for informal care is not available for every caregiver.

5.7.3 Are there tax benefits and allowances for family carers?

There are no tax benefits but the support for informal care is available for family caregivers as has been described in chapter 1.4. See also chapter 6.1.

5.7.4 Does inheritance or transfers of property play a role in caregiving situation? If yes, how?

Usually inheritance or transfers of property do not play an important role in caregiving situations. However, sometimes it is reasonable to have a trustee, especially in the case of the dependent's dementia or some other reason preventing her / him to take care of financial matters. The trustee may be e.g. a spouse, child or a person order by court.

5.7.5 Carers' or Users' contribution to elderly care costs

a. Medical, nursing and rehabilitation services	General access:			Access based on:		
				Means-tested		
	Free at point of use / wholly reimbursed	Partly privately paid / partly reimbursed	Completely privately paid	Partly reimbursed	wholly reimbursed	Based on severity
General practitioner	X					
Specialist doctor		X				
Psychologist	X	X	X			
Acute Hospital	X					
Long-term medical residential care (for terminal patients, rehabilitation, RSA, etc.)	X					
Day hospital		X				
Home care for terminal patients	X					
Rehabilitation at home	X					
Nursing care at home (Day / Night)	X					
Laboratory tests or other diagnostic tests at home	X					
Telemedicine for monitoring						
Other, specify						

b. Social-care services	General access:			Access based on:		
				Means-tested		
	Free at point of use / wholly reimbursed	Partly privately paid / partly reimbursed	Completely privately paid	Partly reimbursed	wholly reimbursed	Based on severity
Permanent admission into residential care / old people's home	X	X				
Temporary admission into residential care / old people's home in order to relieve the family carer	X					
Protected accommodation / sheltered housing (house-hotel, apartments with common facilities, etc.)	X	X				
Laundry service			X			
Special transport services		X				
Hairdresser at home			X			
Meals at home		X				
Chiropodist / Podologist			X			
Telerescue / Tele-alarm (connection with the central first-aid station)	X	X				
Care aids		X				
Home modifications		X				
Company for the elderly			X			
Social worker	X					
Day care (public or private) in community center or old people's home	X		X			
Night care (public or private) at home or old people's home	X	X	X			
Private cohabitant assistant ("paid carer")		X	X			
Daily private home care for hygiene and personal care	X	X				
Social home care for help and cleaning services / "Home help"	X	X				
Social home care for hygiene and personal care	X	X				
Telephone service offered by associations for the elderly (friend-phone, etc.)	X					
Counselling and advice services for the elderly	X	X	X			
Social recreational centre	X	X	X			
Other, specify						

In general services are free if the person is not capable to pay, but usually they have to pay some kind of custom fee which depends of their monthly wage.

c. Special services for family carers	General access:			Access based on:		
				Means-tested		
	Free at point of use / wholly reimbursed	Partly privately paid / partly reimbursed	Completely privately paid	Partly reimbursed	wholly reimbursed	Based on severity
Training courses on caring	X					
Telephone service offered by associations for family members	X					
Internet Services			X			
Support or self-help groups for family members	X		X			
Counselling services for family carers	X		X			
Regular relief home service (supervision of the elderly for a few hours a day during the week)		X	X			
Temporary relief home service (substitution of the family carer for brief periods of time, for example, a week)	X		X			
Assessment of the needs	X					
Monetary transfers		X				
Management of crises	X					
Integrated planning of care for the elderly and families at home or in hospital	X					
Services for family carers of different ethnic groups	X					
Other, specify						

6 Current trends and future perspectives

6.1 What are the major policy and practice issues debated on family care of the elderly in your country from the carers' point of view? Are older people and / or carer abuse among these issues?

There is an administrator set up by Ministry of Social Affairs and Health, who has given proposal for developing the carer-status as a part of social and health services. The report was released on March 30th, 2004. Sixteen improvements have been presented in this report: partly as changes in legislation and partly as development actions (Aaltonen 2004).

- By 2012, the target of the scope of support for informal care: on average 8 % of the number of persons aged over 75s (some 34,000 persons) would be covered by support.
- Attitudes held in working life toward family care should be made more receptive: e.g. shortened working time, remote work, part-time pension, care / nursing leave.
- The support for informal care is intended to support the care work carried out at the home of the disabled older, handicapped or sick person. The carer is a relative for the dependent person.
- The support for informal care consists of three parts: pay of the carer, services of the dependent person, support for the carer (rehabilitation, recreation).
- New criteria and indicators to the support for informal care: a) how much care and solicitude is needed, b) the commitment to caregiving, c) suitability of the carer.
- There will be three classes of support for the informal care in the whole country from 1.1.2006: class I EUR 300 / month, class 2 EUR 600 and class 3 EUR 1000.
- The responsibility of funding of the support will be progressively transferred to the state. Nowadays municipalities take care of it.
- The right to have tax deduction with the support for informal care.
- Carers will receive financial help for the adjustments and renovations needed at home to support the care work and to get the equipment needed.
- The support for informal care should not be taken into account in the definition of other financial support form such as pension of widow or rehabilitation support.

- The quantity of home care, day care and open-centre rehabilitation, home and residential rehabilitation has to be increased.
- The carers have to be taken into account: provide information, physical and emotional support, and also self-help groups, discussion groups, rehabilitation and recreation.
- The carer is entitled to have one two day off per month.
- A working group is to be established in every municipality for evaluating, executing and monitoring caregiving. It will include professionals from social and health care, rehabilitation and The Social Insurance Institution of Finland.
- The judicial support of carer and dependent person will be enhanced in the future.
- The municipalities, associations and different kinds of private service enterprises are expected to work together.

6.2 Do you expect there to be any changing trends in services to support family carers, e.g. more state or more family support, more services or more cash?

As explained above in chapter 6.1.

6.3 What is the role played by carer groups / organisations, "pressure groups"?

There are four big associations for older people (see summary and main findings). The Association of Care Giving Relatives and Friends is the only one which focuses on caregivers while the others focus on older people in general. They all play an important role in the public discussion of elderly and the Association of Care Giving Relatives and Friends especially in the field of family caregiving.

6.4 Are there any tensions between carers' interests and those of older people?

Older people in need of care want to live in their own homes for as long as possible. Family carers have to balance between their own limitations for carrying out caring work (social participation, leisure interests, employment, own partnership) and the dependent´s needs. There is always carer´s feeling of guilty. The role of the spouse will also change to the role of a carer. As the dependent person increasingly looses the ability to take responsibility of his / her share of the household tasks, the responsibilities increase. The carer will get a

greater amount of housework while his / her own physical health and endurance also deteriorate.

6.5 State of research and future research needs (neglected issues and innovations)

A lot of research has focussed on family caregiving in Finland. In particular there have been studies concerning the burden of caregiving. Also different kinds of interventions have been executed to help caregiver families in their daily life. Less is known about how the caregiving families cope with daily life. More research is also needed on husbands as carers (Brewer 2001). The issue of elderly abuse at home and in residential care is not sufficiently studied either (Vaarama et al. 1999b). Services needed by and provided for caregiving families are not in balance (Hyvärinen et al. 2003). Surveys for future planning of services are needed.

6.6 New technologies – are there developments which can help in the care of older people and support family carers?

Innovations in gerontechnology have increased. Different kinds of devices for locomotion in and outside the house, eating, sleeping, toileting and security (e.g. timer for lights, locomotion recognition, security telephone, doorbell alarm, cooker watch) (Mäki et al. 2000). There are also innovations for carers; e.g. so called night alarms. The night alarm is developed to wake the carer up when the person cared for moves from bed during the night.

6.7 Comments and recommendations from the authors

no comments or recommendations provided

7 Appendix to the National Background Report for Finland

7.1 Socio-demographic data

7.1.1 Profile of the elderly population-past trends and future projections

The demographic composition of the Finnish population will change dramatically during the next decades. The share of older people will rise substantially because of the combined effects of increased longevity and ageing of the large post-war baby boom cohorts (Tables 24 and 25). The share of people aged 75 years or more will rise from the 7 % to approximately 14 % in 2030 and their absolute number will double. The population structure is expected to be relatively stable after that (Räty et al 2003, 1).

Table 24: Population by age group at end of year 1990-2030

Age	1990	2000	2010	2020	2030	Change 1990-2030 (%)
65-74	389,897	436,789	505,065	713,197	665,190	70.6
75-84	231,125	262,014	308,769	380,091	554,914	140.1
85+	51,943	78,395	101,235	124,533	169,022	225.4

Source: Kauppinen et al. 2003, 46.

7.1.1.1 Life expectancy at birth (male / female) and at age 65 years

Table 25: Life expectancy at birth 1910-2001

Year of birth	Women	Men
1910	48.1	45.6
1920	49.1	43.4
1930	55.1	50.7
1940	59.6	54.5
1945	61.1	54.6
1950	65.9	58.6
1955	69.8	63.4
1960	71.6	64.9
1965	72.6	65.4
1970	73.6	65.9
1975	75.2	66.7
1980	76.9	68.4
1985	78.2	70.1
1990	78.9	70.9
1995	80.2	72.8
1997	80.5	73.4
1998	80.8	73.5
1999	81.0	73.7
2000	81.0	74.1
2001	81.5	74.6

Source: http://www.stat.fi/.

In 2000 the life expectancy for men at age 60 was 19 years and for women 24 years (Heikkinen 2002, 13).

7.1.1.2 % of > 65 year-olds in total population by 5 or 10 year age groups

Table 26: Older people at the end of year 1990, 1994, 1998 and 2002 (number and percentage of total population)

Year	65-74	75-84	85+	65-74 (%)	75-84(%)	85+ (%)
1990	389,897	231,125	51,943	7.8	4.6	1.0
1994	427,696	228,063	63,959	8.4	4.5	1.3
1998	435,402	248,496	74,922	8.4	4.8	1.5
2002	440,655	276,964	80,945	8.5	5.3	1.6

Source: Kauppinen et al. 2003, 44

7.1.1.3 Marital status of > 65 year-olds (by gender and age group)

Table 27: Marital status of people aged 65 year or older (%) in 2001

Marital status	65-74 years	75-84 years	85+ years
Men			
Married	71.8	68.6	31.7
Common-law marriage	4.5	2.1	0.0
Divorced, separated	7.3	4.8	2.9
Widowed	7.6	17.1	55.9
Single	7.6	17.1	55.9
Women			
Married	45.3	27.5	6.1
Common-law marriage	1.8	1.6	0.0
Divorced, separated	10.9	7.8	4.2
Widowed	33.3	55.0	76.4
Single	8.7	8.2	13.3

Source: Martelin et al. 2002, 18.

7.1.1.4 Living alone and co-residence of > 65 year-olds by gender and 5-year age groups

The number of older people living alone has increased in Finland. In 2000 every second of the 65+ households and almost 60 % of the 75+ households were single-person households (table 28) (Kauppinen et al. 2003, 49).

Table 28: Single-person households 1990-2000

	1990 N, (% of similar households)	1995 N, (% of similar households)	2000 N, (% of similar households)
Single-person households	646,229 (31.4 %)	766,636 (35.2 %)	856,746 (37.3 %)
Households with one over 65 person	246,318 (60.5 %)	276,223 (50.4 %)	290,629 (50.7 %)
Households with one over 75 person	123,838 (70.7 %)	140,885 (58.5 %)	157,727 (58.8 %)

Source: Kauppinen et al. 2003, 49.

7.1.1.5 Urban / rural distribution by age (if available and / or relevant)

The majority of the people aged 65 or older are living in town and about one third on countryside (Table 29).

Table 29: Place of living by age among people aged 65 or older in 2001

Place of living	65-69	70-74	75-79	80-84
Men				
Town	51.3	55.3	57.9	52.7
Densely populated community	15.7	8.9	13.2	13.2
Countryside	33.0	35.9	28.9	34.2
Women				
Town	55.9	55.0	52.7	57.7
Densely populated community	13.7	13.9	15.2	18.6
Countryside	30.5	31.1	32.1	32.7

Source: Sulander et al. 2001.

7.1.1.6 Disability rates among > 65 year-olds. Estimates of dependency and needs for care

In the following the disability rate of population aged 65 or older has been estimated on the basis of PADL- and IADL-functions (Tables 30-32). Tables show the share of people with no difficulties in functions.

Table 30: No difficulties in selected PADL-functions (%) in 2001

PADL-function	Gender	65-74	75-84	85+	65+*
Dressing	Men	90.7	74.5	51.6	81.1
	Women	91.9	77.2	45.7	82.8
Washing	Men	94.5	76.8	54.3	84.1
	Women	95.9	77.0	41.0	84.6
Cutting toenails	Men	80.2	51.2	16.8	95.8
	Women	78.0	48.6	17.6	95.6

* age-standardized
Source: Koskinen et al. 2002, 72.

Table 31: No difficulties in locomotion ability (%) in 2001

Function	Gender	65-74	75-84	85+	65+*
Moving in the apartment	Men	95.3	82.9	62.2	87.5
	Women	94.0	77.6	42.4	83.6
Climbing the stairs (one flight)	Men	85.1	63.3	25.1	72.1
	Women	75.1	48.8	21.6	61.9
Walking ½ kilometres	Men	81.7	59.1	17.1	67.7
	Women	76.9	47.2	18.3	62.0
Carrying the shopping bag (5 kg) for 100 metres	Men	83.4	57.8	24.8	69.0
	Women	64.9	31.7	10.3	49.3

* age-standardized
Source: Koskinen et al. 2002, 72.

Table 32: No difficulties in selected IADL-functions (%) in 2001

Function	Gender	65-74	75-84	85+	65+*
Shopping	Men	91.1	70.8	39.7	78.9
	Women	87.6	61.8	23.5	73.3
Heavy cleaning	Men	72.5	41.5	5.9	55.6
	Women	54.1	23.9	5.0	40,0

* age-standardized
Source: Koskinen et al. 2002, 72.

7.1.1.7 Income distribution for top and bottom deciles i.e. % aged > 65 years in top 20 % of income, or % > 65s in top 20 %, and the same for poorest 20 % income groups

Monthly income rate (table 33) and poverty (table 34) among people aged 65 years or older are shown in the following.

Table 33: Income / month in households, according to age and gender in 2001 (%)

Income / month in households €	Men, age 65-74	Women, age 65-74	Men, age 75+	Women, age 75+
< 2000	4.7	3.4	2.4	4.2
2001-4000	18.5	14.3	12.5	4.9
6001-8000	17.2	19.1	30.4	30.9
8001-10 000	9.4	8.5	5.6	3.7
> 10 000	6.9	11.4	12	7.8

Source: Vaarama, Kaitsaari 2002, 125.

Table 34: Poverty of older people in 1985 and 1995, 40, 50 and 60 % of median income (the new table of OECD)

	40 % of median income		50 % of median income		50 % of median income	
	1985	1995	1985	1995	1985	1995
Man+65	0	0	3.5	4.2	21.1	13.0
Woman+65	1.4	0.2	12.7	7.8	37.1	25.8
Couple+65	0.5	0.5	2.0	0.6	8.3	3.1
Whole population	2.2	1.5	4.5	3.7	9.2	7.6

Source: Mäkinen 2003, 143-144.

7.1.1.8 % > 65 year-olds in different ethnic groups (if available / relevant)

This is not relevant in Finland, so far.

7.1.1.9 % Home ownership (urban / rural areas) by age group

On average in 2001 58.5 % of Finns lived in owner-occupied flats and 30.6 % in rented flats. 54 % of Finns lived in detached houses and 43.4 % in blocks of flats (Vaarama, Kaitsaari 2002).

7.1.1.10 Housing standards / conditions if available by age group e.g. % without indoor plumbing, electricity, TV, telephone, lift (if above ground floor), etc.

On average Finns live in well-equipped housing. However some people live in accommodation of a poor standard. The total share of poorly or very poorly equipped household-dwellings decreased between 1990 and 2000. But between 1995 and 2000 the number of older people living in poorly equipped housing has increased. A dwelling is regarded as poorly equipped, if it has no washing facilities and / or central / electric heating. It is regarded as very poorly equipped, if it lacks one of the following: piped water sewer, hot water of flush toilet (Kauppinen et al. 2003, 50). Level of accommodation among people aged 65 or older in 2001 is shown in table 35 and weaknesses perceived in housing and neighbourhood in table 36.

Table 35: Level of equipment of dwellings by age and gender 2001

	Persons in well equipped housing	Persons in poorly equipped housing	Persons in very poorly equipped housing
All aged 65 and over	625,467 (83.5 %)	54,319 (7.3 %)	68,958 (9.2 %)
Women	383,252 (846 %)	31,544 (7.0 %)	38,108 (8.4 %)
Men	242,215 (81.8 %)	22,775 (7.7 %)	30,850 (10.4 %)
All aged 75 and over	261,685 (82.4 %)	25,308 (8.0 %)	30,535 (9.6 %)
Women	177,065 (83.2 %)	16,178 (7.6 %)	19,607 (9.2 %)
Men	84,629 (80.8 %)	9,130 (8,7 %)	10,928 (10.4 %)
All aged 85 and over	51,213 (81.9 %)	4,992 (8.0 %)	6,328 (10.1 %)
Women	38,154 (82.5 %)	3,509 (7.6 %)	4,568 (9.9 %)
Men	13,058 (80.1 %)	1,483 (9.1 %)	1,760 (10.8 %)

Source: Kauppinen et al. 2003, 52.

Table 36: Weaknesses perceived in housing and neighbourhood (%)

Weakness	Gender	65-74	75-84	85+
Confined housing	Men	2.1	9.0	0.0
	Women	2.5	1.2	2.9
Barriers of movement at home	Men	8.2	14.1	32.9
	Women	12.4	22.3	24.5
Deficiencies in washing possibilities	Men	5.7	5.1	9.4
	Women	3.8	4.6	4.1
Deficiencies in storage and preparation of food	Men	1.6	1.3	0.0
	Women	1.9	2.5	1.8
Insecurity of residential environment	Men	5.0	5.2	6.5
	Women	12.4	14.7	19.2

Source: Martelin et al. 2002, 23.

7.2 Examples of good or innovative practices in support services

There are dozens of innovative practises in support services. Some of them are briefly introduced in the following.

- *VERROKKI* - Training peer group leaders for care groups (2001-2004): The project was carried out in co-operation with 13 social associations. It is developing peer group activities in order to find new and promote old ways of providing emotional support for the family caregivers.
- *COMBINING WORK AND FAMILY CAREGIVING – PROJECT* (2002-2005): In the future the number of elderly people is increasing. Many working people are going to meet challenges when trying to combine work

and caring for elderly parents. Working parents of handicapped children and spouse caregivers also share the same situation. The project is trying to find out good practices of supporting working family caregivers.

- *CHARITY COLLECTION TO THE CARE GIVERS 2001-2003* – In 2001 Lutheran Church charity collection targeted to 17.5 % of total collected funds to the Association of Care Giving Relatives and Friends. The project was called " Best Carers". The theme of the charity collection in 2001 was "Take care of each other". The goal of this project was to raise awareness of the needs of carers at all levels (e.g. governmental and societal levels) and to ensure some action to support them. When helping the carers, the whole family becomes more aware of their roles, resources and status in their life situations. This project found caregivers who did not receive any support from parishes and regional associations. The project also arranged resource-weeks and 3-5 days´ courses specifically targeted to elderly caregivers and care recipients as well as families with handicapped children. The project also collected information about the caregivers´ life situations and needs. Producing information materials and training were included in the project.
- *CARMEN (2001-2003)* - Care and management of services for older people: a European network. This network was funded by the European Commission's *Directorate General for Research* for a three-year period (March 2001 - February 2004). It was coordinated and managed by the European Health Management Association. The CARMEN project was closely connected to one of the key priorities of the European Commission's 5th framework programme (1998-2002): contributing to 'the evolution of effective, efficent and user-friendly care services for older people.' Further documents on this project, will be posted on the project's website at www.carmen-network.org as soon as they become available. Source: http://www.omaishoitajat.com/.

Forms of support used in development projects of family caregiving:

- training and couselling of family caregivers
- arrangement of leisure time for family caregivers
- recreational activities for family caregivers
- support and peer groups for family caregivers

Source: Pietilä, Saarenheimo 2003.
The projects are often funded by Finland’s Slot Machine Association.

Associations of family caregiving arrange projects funded by Finland´s Slot Machine Association. The purpose of the projects is mainly to support and help everyday life of the carer and the person cared for. As an example, the Association of familycarers in the Jyväskylä district has implemented a project which aims as supporting the beginning familycaring. Many times it is, how-

ever, difficult to define the beginning of the caring work, because in reality it may have started long before a spouse has considered himself / herself as a family carer. In the same association a new project has recently been started with the aim of developing new ways of supporting family carers. One of the objectives of this project is to develop an occupational health care system for familycarers to take care of their health and well-being. In addition, the local associations have many kinds of peer groups. Rehabilitation and recreational activities funded by Finland´s Slot Machine Association and provided with lower personal costs are also arranged for family carers.

Dementia associations also have different kinds of projects for demented people and their families. E.g. Southern Karelian Dementia Association had a project in 1996-1999 to study the effect of half-day help given to dependent person's home by a personal home help / nurse. This project studied 168 families, and family carers perceived that the project had helped their life and provided more time just for themselves (Viitakoski 2001).

In Helsinki, The Central Union for the Welfare has started a one-year study focusing on personally tailored support for spouses as caregivers for demented persons. In this study 128 families have been enrolled with one half of them comprising the control group. Families in the study group get a personal nurse who makes a support plan on the basis of the needs of this specific family. In addition family caregivers take part in support group. The purpose of the project is to look at the effects of the support offered on the well-being of the familycarer and the delay in the time before institutional care is needed for the demented person.

8 References to the National Background Report for Finland

Aaltonen E. 2004. Valtakunnallinen omaishoidon uudistaminen. Sosiaali- ja terveysministeriön työryhmämuistio 2004:3. Helsinki. Available online www.stm.fi

Ageing and Employment Policies, Finland. OECD-report. Available online www.stm.fi

The Association of Finnish Local and Regional Authority 2004. Kuntien järjestämät vanhusten palvelut vuonna 2002. Available online www.kunnat.net. (In Finnish)

Brewer L. 2001. Gender Socialization and the Cultural Construction of Elder Caregivers. Journal of Aging Studies 15, 217-235

The client fees of public health services in 2004. Available online http://www.stm.fi/ (In Finnish)

Employment policy research 2002. Employment in the beginning of 2000. Labour in 2020. Ministry of Labour. Helsinki. Available online www.mol.fi/julkaisut/ (In Finnish)

Employment policy strategy 2003-2007-2010. (Työpolitiikan strategia 2003-2007-2010.) Number 334. The Ministry of Labour. Helsinki. Available online http://www.mol.fi/ (In Finnish)

Health service cost and funding in 2001. Stakes. Statistics bulletin 3. 2003. Available online www.stakes.info (In Finnish)

Heikkilä M, Kaakinen J, Korpelainen N. 2003. The National Development Project for the Social Welfare Field The Ministry of Social Affairs and Health 2003:11. Helsinki. Available online www.stm.fi (Documentation page in English)

Heikkinen E. 2002. Sairauksista toimintakykyyn. In M Marin, E Heikkinen (eds.) Vanhuuden voimavarat. Tammi. Vammala

Hujanen T. 2003. Terveydenhuollon yksikkökustannukset Suomessa vuonna 2001. Stakes. Helsinki. Available online http://www.stakes.fi/ (in Finnish)

Hyvärinen M, Saarenheimo M, Pitkälä K, Tilvis R. 2003. Vanhusten omaishoitajat ja tukitoimet. Duodecim 119, 1949-1955

Hännikäinen I. 1998. Vaimot sotainvalidien rinnalla. Elämäntehtävänä selviytyminen. Gaudeamus. Tampere

Ilmarinen J. (1999). Ikääntyvä työntekijä Suomessa ja Euroopan Unionissa – tilannekatsaus sekä työkyvyn, työllistyvyyden ja työllisyyden parantaminen.

The National Public Health Institute, The Ministry of Social Affairs and Health, Ministry of Labour. Helsinki. (In Finnish)

Jylhä M, Salonen P, Mäki O, Hervonen A. 1996. The 25-hour day. Relatives´ experiences of life with a dementia patient. Stakes Reports 196. Helsinki. (Summary in English)

Kauppinen S, Forss A, Säkkinen S, Noro A, Voutilainen P. 2003. Care and Services for Older People 2002. Stakes. Official Statistics of Finland (SVT). Social Security 2003:1. Saarijärvi

Kautto M, Moisio P. 2002. Suomalaisten köyhyys vertailevasta näkökulmasta. In M Heikkilä, M Kautto (eds.) Suomalaisten hyvinvointi 2002. STAKES. Jyväskylä. 312-335.

Koskinen S, Sainio P, Gould R, Suutama T, Aromaa A, Era P, Forma P, Haavisto P, Halonen J-P, Husman K, Ilmarinen J, Järvisalo J, Karppi S-L, Malmberg J, Mannila S, Lassila J, Valkonen T. 2002. Sosiaalimenot ja väestön ikääntyminen. The Reseach Institute of the Finnish Economy. Helsinki

Lehto J. 1997. Palvelut kotiin vai koti palvelujen luo? Hyvinvointikatsaus 2.

Lehto J, Aalto A-R, Päivärinta E, Järvinen A. 1997. Mistä apu ikääntyneille? Tuloksia yhdeksän kunnan 75 vuotta täyttäneille tehdystä kyselystä. Stakes. Aiheita 19. Saarijärvi

Luoma K, Räty T, Moisio A, Parkkinen P, Vaarama M, Mäkinen E. 2003. Seniori-Suomi. Ikääntyvän väestön taloudelliset vaikutukset. Sitran raportteja 30. Helsinki. Available online www.sitra.fi/

Martelin T, Nieminen T, Heikkilä M, Kainulainen S, Kauppinen T, Lahelma E, Mannila S ja Notkola V. Sosiodemografiset tekijät ja elinolot. In A Aromaa, S Koskinen (eds.) Terveys ja toimintakyky Suomessa. Terveys 2000 – tutkimuksen perustulokset.. KTL- National Public Health Insitute Finland, Department of Health and Functional Capacity. Helsinki 16-24. Available online http://www.ktl.fi/

Marttila T, Miilunpalo S, Ojamo M, Rudanko S-L, Räty S, Sulkava R, Tilvis R, Vaara M. 2002. Functional capacity and working capacity. (Toimintakyky ja työkyky.) In Aromaa A, Koskinen S, ed. Health and functional capacity in Finland. Baseline results of the Health 2000 health examination survey.. Publications of the National Public Health Institute B3 / 2002. Helsinki. 71-97. Available online http://www.ktl.fi/ (Abstract in English)

The Ministry of Social Welfare and Health. Bulletin 13.10.2003. Available online www.stm.fi (In Finnish)

Mäki O, Topo P, Rauhala M, Jylhä M. 1999. Teknologia dementiahoidossa. Eettinen näkökulma päätöksentekoon. Stakes oppaita 37. Saarijärvi

Mäkinen T. 2003. Suomalaiseläkeläisten asema kansainvälisen vertailun valossa. In R Hagfors, K Hellsten, S Ilmakunnas, H Uusitalo. Eläkeläisten

toimeentulo 1990-luvulla. Research of The Finnish Centre for Pensions 1. Helsinki. 133-148

The national recommendations for the development and quality of services for older people 2001. The Ministry of Social Affairs and Health guidelines 2001:4. Helsinki. Available online www.stm.fi (In Finnish)

Old age policy 1999. The Ministry of Social Welfare and Health. Available online www.stm.fi (In Finnish)

Parkkinen P. 2002. Hoivapalvelut ja eläkemenot 2050. Valtion taloudellinen tutkimuslaitos. Tutkimuksia 94. Helsinki. Available online www.vatt.fi

Pietilä M, Saarenheimo M. 2003. Omaishoidon tukeminen Suomessa. Geriatrisen kuntoutuksen tutkimus—ja kehittämishanke. Vanhustyön Keskusliitto. Saarijärvi

Pocket information booklet of social and health services 2003. Available online http://www.stakes.info/ (In Finnish)

Päätalo M, Suorsa S, Hämäläinen P. 2003. National Review 2002 of primary social and health care services. The network of health services to older people´s coping at home. Ministry of Social Affairs and Health Review 14. Available online www.stm.fi (Summary in English)

Report in Social Affairs and Health 2002. Publications of the Ministry of Social Affairs and Health 11. Helsinki. Available online www.stm.fi. (Summary in English)

Räty T, Luoma K, Mäkinen E, Vaarama M. 2003. The Factors Affecting the Use of Elderly Care and the Need for Resources by 2030 in Finland. Government Institute for Economic Research 99. Helsinki. Available online www.vatt.fi/

Sihvo T. (1989). Arki ja apu. Sosiaalihallituksen väestötiedustelun raportti 1. Sosiaalihallituksen julkaisuja 14 / 1988. Helsinki

Stakes & National Authority of Medicolegal Affairs 2003. Työikäiset erikois- ja erikoistumattomat lääkärit suuralueittain ja maakunnittain 31.12.2002. Available online www.stakes.info. (In Finnish)

Sulander T, Helakorpi A, Nissinen A. (2001). Health Behaviour and Health among Finnish Elderly, Spring 2001, with trends 1993-2001. Helsinki. National Public Health Institute, Finland. Department of Epidemiology and Health Promotion. Health Promotion Unit B17. Available online http://www.ktl.fi/

TATO 2000-2003. 2003. Follow-up publication of the Target and Action Plan for Social Welfare and Health care 2000-2003. The Ministry of Social Welfare and Health. Available online www.stm.fi (Summary in English)

Vaarama M, Hakkarainen A, Laaksonen S. 1999a. Old age barometer. The Ministry of Social Welfare and Health 3. Helsinki. (Summary in English)

Vaarama M, Kainulainen S, Perälä ML, Sinervo T. 1999b. Vanhusten laitoshoidon tila. Voimavarat, henkilöstön hyvinvointi ja hoidon laatu. Stakes 46. Helsinki

Vaarama M, Kaitsaari T. 2002. Ikääntyneiden toimintakyky ja koettu hyvinvointi. In M Heikkilä, M Kautto (eds.) Welfare in Finland in 2002. Suomalaisten hyvinvointi 2002. Stakes. Jyväskylä. 120-148

Vaarama M, Luomahaara J, Peiponen A, Voutilainen P. 2003a. The Whole municipality working together for older people. Perspectives on the Development of Elderly People´s Independent living, care and services. Stakes. Saarijärvi

Vaarama M, Voutilainen P, Manninen M. 2003b. Support for informal care as a social service. Report on support for informal care and its variation 1994 – 2002. Reports of the Ministry of Social Affairs and Health 2003:8. Helsinki. Available online www.stm.fi (Summary in English)

Valvanne J, Huusko T, Sulkava R. 2001. Geriatrinen kuntoutus. In R Tilvis, A Hervonen, P Jäntti, A Lehtonen, R Sulkava (eds.) Geriatria. Duodecim. Hämeenlinna. 343-368

Valvanne J, Noro A. 1999. Milloin laitoshoitoon? Duodecim 115, 1591-1599

Viitakoski K. 2001. Rinnalla kulkien – vierellä kokien. Nimikkohoitaja keskivaikeasti tai vaikeasti dementoituneen henkilön ja häntä hoitavan omaisen tukena. Lisensiaattityö. Jyväskylän yliopisto. Terveystieteiden laitos. Jyväskylä